23.a. Transportation

Services provided by an ambulance provider under the Medicaid program must be demonstrated to be medically necessary and are subject to limitations described herein. Medical necessity is indicated when the patient's condition is such that any other means of transportation would endanger the patient's health. Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized.

a. Emergency ambulance transportation for the client to receive immediate and prompt medical services arising in an emergency situation. Emergency transportation to a physician's office is covered only if all the following conditions are met:
   (1) The patient is enroute to a hospital.
   (2) There is medical need for a professional to stabilize the patient's condition.
   (3) The ambulance continues the trip to the hospital immediately after stabilization.

b. Non-emergency ambulance transportation to and from a physician directed office/clinic or other medical facility in which the individual is an inpatient is covered in the following situations:
   (1) Medical necessity is indicated when the use of other means of transportation is medically contraindicated because it would endanger the patient's health. This refers to clients whose medical condition requires transport by stretcher.
   (2) Client is in need of medical services that cannot be provided in the place of residence.
   (3) Return transportation from a facility which has capability of providing total care for every aspect of injury/disease to a facility which has fewer resources to offer highly specialized care.

c. In order to claim Medicaid reimbursement, providers of ambulance services must be able to document that ambulance services were medically necessary.
   (1) The UB-92 claim form must describe the recipient's medical condition at the time of transport by using appropriate condition codes to demonstrate that transportation by any other means would be medically inappropriate.
   (2) A legible copy of the ambulance call report to support the condition codes used must be kept on file by the provider for five (5) years which indicates:
      a. the purpose for transport,
      b. the treatments,
      c. the patient's response; and
      d. the patient's condition that sufficiently justifies transport by stretcher was medically necessary.

d. Prior approval is required for non-emergency transportation for recipients to receive out-of-state services or to return to North Carolina or nearest appropriate facility.

23.d. Skilled Nursing Facility Services for Patients Under 21 Years of Age

Limitations and prior approval same as described in Item 4.a. Skilled Nursing Facility Services.

23.f Personal Care Services

a. The number of hours of personal care services received by a Medicaid beneficiary may not exceed eighty (80) hours per calendar month.

b. Licensed home care agencies are enrolled for Personal Care Services rendered in private residential settings. The agency must be a State licensed home care agency that is approved in its license to provide in-home aide services within the State.

c. All Medicaid beneficiaries residing in licensed domiciliary care facilities receive Personal Care Services provided by the facilities. The Division of Medical Assistance contracts with each facility for the service. Licensed domiciliary care facilities are public or private non-medical institutions.

d. The need for enhanced personal care services beyond the amount of one hour per resident day in the basic (capitated) rate for domiciliary care facilities is based on a case manager's evaluation of a resident's care requirements for extensive or total assistance in eating or toileting and must be authorized by a physician.